

# Editorial

## Reflection on End-of-Life Care

B. Jay Brooks, MD, FACP

Department of Hematology-Oncology, Ochsner Health Center—Baton Rouge, Baton Rouge, LA

When I was asked to write an article on end-of-life care from the perspective of an oncologist, I began to think back over the past 25 years in my specialty. When I graduated from medical school, I received a gift from a friend of 6 simple words—"Cure Seldom, Relieve Sometimes, Comfort Always"—that was over the doorframe of the original Hôtel-Dieu de Paris. Little did I know how important these words would become in my career as an oncologist. We physicians tend to forget in the 21st century that long before we had therapies such as potent antibiotics, extensive surgery, and powerful chemotherapy agents that can cure many patients, our job was mainly to relieve and to comfort. Although I have received the least amount of training in the relief and comfort aspects of medical care, they have become major components of my practice and are areas in which I feel that I am most valuable to my patients.<sup>1</sup> Educating the patient and family on the illness, treatment options, and prognosis will help them all prepare for the end of life with realistic expectations.

While realizing that all of us will die, physicians try to prevent untimely and avoidable deaths. As a cancer physician, many times I have been asked to see patients who have *incurable* but *treatable* cancers. I stress these 2 words to my patients. We need to recognize the issue of incurability and to be honest with our patients when we evaluate them.

Many years ago, one of my mentors from the National Cancer Institute (NCI) told me that when you first see a patient with cancer, you should ask yourself

whether the patient has a curable or incurable cancer and then provide this very critical information to the patient at the very first visit. Many physicians tend not to follow this approach, but I believe that being honest with patients about their illnesses can go a long way in setting appropriate expectations for future care.<sup>2</sup>

When I began to treat patients 25 years ago, most patients obtained information about their disease from the public library. Now, however, many more sources of information are available. The explosion of information available on the internet has, for the most part, been extraordinarily valuable to our patients. I have always given my patients their pathology reports, articles to review, and information from NCI's website and other helpful sites, such as UpToDate, to describe the risks, benefits, and limitations of available treatments for their malignancies. We as physicians should be honest with our patients about their illnesses because if we are not, they will likely find the information on the internet anyway and the sacred trust between patient and doctor may be shattered. The physician communicating this information face-to-face is preferable to an alone and frightened patient reading about it on a website.

The use of palliative care has been underutilized in patients with treatable but incurable malignancies. A recent article demonstrated the effect of early palliative care intervention in patients with metastatic non-small-cell lung carcinoma receiving chemotherapy.<sup>3</sup> In this study, the patients receiving chemotherapy plus palliative care lived an average of 3.5 months longer than patients treated with standard chemotherapy alone. This valuable information shows the importance of using palliative care in treating patients with ultimately fatal malignancies. Again, open, honest discussion with our patients about setting appropriate expectations and goals can be the most valuable element of their treatment.

Declining performance in daily living activities is an important clinical factor for guiding our advice to patients.<sup>4</sup> For instance, observations of increasing somnolence during the day and decreasing appetite are key predictors of end of life, as Seow and

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Address correspondence to  
B. Jay Brooks, MD, FACP  
Department of Hematology-Oncology  
Ochsner Health Center—Baton Rouge  
9001 Summa Avenue  
Baton Rouge, LA 70809  
Tel: (225) 761-5446  
Fax: (225) 761-5508  
Email: jbrooks@ochsner.org

colleagues recently demonstrated.<sup>4</sup> Oncologists, and indeed all physicians, should pay particular attention to these key clinical factors and explain them to our patients and their families so they can better prepare for the decline in the patient's condition and have appropriate expectations for his or her care. Our goal should be an expected, peaceful death.

I would like to say that the care of patients near the end of life is extraordinarily rewarding. When a patient's family returns many months or years after the person's death and thanks you for the care that you gave, I can think of no greater or more rewarding testament.

## REFERENCES

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